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F 000	INITIAL COMMENTS Surveyor: 12211 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from October 20, 2009 through October 26, 2009. The census at the beginning of the survey was 223. Thirty-one residents were sampled and 3 closed records were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 12211 Based on interview, policy review, and record review, the facility failed to implement and maintain the written policies and procedures regarding abuse of residents. Findings include:	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 Policy Review Policy regarding abuse and neglect of residents (undated) "Protection of Residents: Reducing the Threat of Abuse & Neglect, Chapter 2: "...Sexual Abuse: Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault...The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. The facility must develop and implement policies and procedures that include seven components: I. Screening employees for a history of abuse/neglect. II. Training employees through orientation and ongoing education on issues related to abuse/neglect including redirecting behaviors, reporting alleged abuse/neglect, recognizing signs of burnout of stress and what constitutes abuse, neglect and misappropriation of resident property. III. Prevention including informing residents, families and staff how to report concerns, incidents and grievances without the fear of retribution; and follow up and provide feedback on the concerns that have been expressed. Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur. IV. Identification procedures to identify events, such as suspicious bruising, occurrences and patterns that may constitute abuse. V. Investigation procedures for different types of incidents and staff members responsible for	F 226		

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investigating and reporting alleged abuse/neglect.
VI. Protection of residents from harm during an investigation.
VII. Reporting/Response procedures...
(Page 2-18): Reporting Alleged Abuse:
1. All personnel, residents, families, and visitors are encouraged to promptly report incidents of suspected resident abuse and/or neglect to facility administration.
2. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) will be promptly reported to the administrator and/or director of nursing..."

Resident #25

Resident #25 was a 72 year old male admitted 10/14/07. with diagnoses including Amputee Below Knee, unilateral, Muscle Weakness-General, Difficulty in Walking, Joint Contracture-Left Leg, Diabetes Mellitus II, and Hypertension.

The facility submitted a self report to the Bureau of Health care Quality and Compliance indicating a sexual abuse incident on 8/12/09, between Resident #25 and a non-cognitive female resident. However, based on the witness statements, a previous incident on 8/11/09, regarding possible sexual abuse of 8/11/09 between the 2 residents was witnessed, as recorded by staff members on 8/11/09. There was no documented evidence the facility intervened and protected the female resident following the 8/11/09 incident.

The Executive Director and the Director of

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F 226	Continued From page 3 Nursing (DON) indicated they were the designated Abuse Coordinators. Based on interview with the Administrator and the Director of Nursing (DON) on the afternoon of 10/23/09, they were not aware of the incident of sexual activities between the non-cognitive female resident and Resident #25, which occurred in the female's room on 8/11/09. It was further verified the facility did not take immediate action following the 8/11/09 incident to supervise the female resident to ensure she did not have further contact with the male resident on the morning of 8/12/09. Surveyor: 13766 Resident #24 Resident #24 was an 89 year old male admitted to the facility on 8/25/09, with diagnoses to include Alzheimer's Disease, History of falls, Difficulty walking, Hypertension, Chronic Kidney Disease. Resident #24's Care Plan dated 10/20/09, contained the following documentation: "Problem/Need - Resident #24's name has a history and potential to make sexual innuendos/statements to staff /others such as, 'I want to have sex with you'." Social Service notes dated 10/20/09 documented, "Staff reported to this social worker that resident was heard making sexual statements such as, "I want to have sex with you." Resident care planned and staff to follow care plan when addressing this issue. Resident alert with confusion and hx (history) of making such statements per spouse."	F 226		

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F 226	Continued From page 4 The documentation in Resident #24's Care Plan dated 10/20/09, failed to identify who the "others" were concerning the resident's inappropriate sexual statements. The Social Service Notes dated 10/20/09, did not identify who Resident #24 spoke to when he indicated, "I want to have sex with you." On 10/26/09 in the morning, the Executive Director (Abuse Coordinator) indicated she was unaware of the incident concerning Resident #24	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 27178 Based on observation and interview, the facility failed to ensure an environment that maintained residents' dignity and respect (Resident #22, #27, #28, #32, #33, #34 and #35). Findings include: Dining Room: On 10/22/09, at 7:00 AM during meal observation in 100 and 300 hall dining area, Employee #17 was observed feeding three residents at the same time. Employee #17 was seated between Resident #34	F 241		

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and Resident #27. Resident #33 was seated next to Resident #27.

Employee #17 was observed to have gotten up multiple times to feed Resident #33.

Employee #17 revealed, it was not unusual to have two to three "feeders" at the same time.

Employee #17 further revealed, Resident #33 would normally eat on her own, but at times would need to be encouraged or fed.

On 10/22/09 at 8:30 AM, the Director of Nurses revealed Certified Nursing Assistants (CNA), "Normally get two feeders. The CNAs would at times get a third resident to feed if that third resident is not really a feeder or if that resident can sometimes manage to feed herself."

Resident's Room:

On 10/23/09 at 2:30 PM, Employee #16 knocked on Resident #32's door and immediately walked into the room to check the soap dispenser by the sink. Soon after checking the soap dispenser, Employee #32 quickly walked out of the room.

Employee #16 failed to ask for permission to enter the room.

Resident #32 and the roommate revealed, "They do that sometimes. They would knock but they're already inside our room or they would knock as they are already walking into our room."

Surveyor: 13766

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F 241	Continued From page 6 Resident #22 On 10/21/09 at 12:15 PM, Resident #22 was in bed yelling loudly, "Yo quero (I want to in Spanish) pee-pee." The resident continued to yell until a Certified Nurse's Assistant went into the room at 12:45 PM to assist her with her lunch tray. Resident #22 was observed to have been incontinent of urine. Resident #28 Resident #28 was a 78 year old male admitted to the facility on 9/26/06, and readmitted on 1/30/08, with diagnoses to include Hypoglycemia, Atrial Fibrillation, Urinary Tract Infection, Hypertension, Diabetes Insipidus, Muscle Weakness and Difficulty Walking. On 10/22/09 during lunch time, Resident #28 was observed in his room sitting in his wheelchair. The resident indicated he was very angry because he had been told by the staff he could no longer eat in the dining room and was confined to his room. Resident #28 indicated he was not sure why he was confined to his room. However he indicated one of the nurses told him he had a contagious eye infection. He indicated he had this condition for weeks and he had been going to the dining room and activities. He indicated he felt he was being treated unfairly because he did not understand what was going on with the room confinement. The Medication Nurse entered the room of Resident #28 to administer his Accucheck. Resident #28 started toward the door, the Medication Nurse indicated to Resident #28 to, "Remember what we talked about, stay on your	F 241		

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F 241	Continued From page 7 side of the room for now." Surveyor: 25418 On 10/22/09, during lunch in the 400 Hall Dining Room, Unsampled (male) Resident #35 independently ate the bite sized cubes of potatoes and vegetables on his plate. Unsampled Resident #35 attempted to cut the piece of ham (measuring approximately four inches wide by five inches long and just under half an inch thick). After cutting the ham into three large pieces, the resident managed to get a piece in his mouth and attempted to chew it for approximately 15 seconds. The resident then returned it to the plate. The resident did the same with the second and third pieces. As Unsampled Resident #35 returned the third piece of partially chewed ham to the plate, he told an employee who was a couple of feet away, "This meat is too tough - I can't chew it." The employee offered to get the resident an alternate lunch. None of the four employees assisting and monitoring the residents offered to cut the meat up for Unsampled Resident #35. On 10/23/09 at 7:17 AM, the 400 hall Unit Manager was observed standing up while feeding one of the residents in the 400 hall dining room.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		

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objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Surveyor: 27178
Based on observation, interview and document review, the facility failed to initiate and/or follow written care plans for 5 of 31 residents (#4, #26, #2, #24, and #28).

Findings include:

Resident #4

Resident #4 was admitted on 11/08/08, with diagnoses including Alzheimer's Dementia, Cerebrovascular Accident with Left Dense Hemiparesis and Left Hand Flexion Contracture, History of Anemia, Chronic Sigmoid Colon Distention, Left foot drop, Chronic Ileus, Osteoarthritis and Chronic Pain Syndrome.

The Minimum Data Set, dated 2/17/09, 5/19/09 and 8/18/09 revealed, Resident #4 had limited range of motion to the leg and the foot with no

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loss of voluntary movement.

On 10/22/09, Resident #4's feet were noted to have foot drop.

The Physical Therapy notes, dated 11/19/08 revealed, Resident #4 would tolerate the use of bilateral foot/ankle positioning device for plantarflexion contracture for 4 hours.

The Physical Therapy notes, dated 12/31/08 revealed, "Pt. (Patient) has been on PT program since 11/19/08. Pt. shows significant gains with BLE (bilateral lower extremity) ROM (range of motion). This allowed nursing to do better pericare. On initial evaluation, pt's LE (lower extremities) were in extension...Patient has tolerated use of bilateral foot drop splint for at least 6 hours. Nursing and family has been instructed with use of splints. Pt. ready for discharge from PT program..."

The Nurses Notes, dated 12/31/08 revealed, "BLE worn @ 7 AM and taken off at 11 AM."

The Nurses Notes, dated 1/11/09 indicated, "Patient's son states that he doesn't want her (Resident #4) to use the boots anymore because he cant bend the knees but wants the hand splint on."

There was no care plan found in Resident #4's chart addressing the foot drop and was confirmed by the Director of Nurses (DON) on 10/22/09 in the afternoon.

The DON further confirmed the lack of assessments and interventions in preventing further foot drop.

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F 279	Continued From page 10 Surveyor: 12211 Resident #26 Resident #26 was a 93 year old female admitted 4/15/08, with diagnoses including Late Effective Hemiplegia Non-dominant, Difficulty Walking, Muscle Weakness, Dysphasia Oropharyngeal, Dementia, Cerebral Vascular Accident, Coronary Artery Disease, Thyroid Disease, Urinary Incontinence, and General Weakness. The room that Resident #26 resided on 10/20/09, 10/21/09, 10/22/09, 10/23/09, and 10/26/09, did not have a sign indicating any contact precautions to be taken by staff, residents, and visitors. Nursing Notes 10/17/09 1100 (11:00 AM) indicated, "Noted resident's left eye is red and has yellowish drainage. Notified (name of treating physician) and noted order for erythromycin eye ointment 1/2 inch ribbon twice a day x 7 days to left eye..." There was no documented evidence in the Nursing Notes that any contact precautions were put into place for Resident #26. There was no documentation of an assessment for Resident #26 regarding whether the left eye redness with yellow drainage was Conjunctivitis and contagious. . The Care Plan, dated 10/17/09, did indicate that antibiotics for the left eye were prescribed; however, there was no documented evidence of a care plan for contact precautions. Resident #2 Resident #2 was an 84 year old male admitted 8/13/09, with diagnoses including Atrial Fibrillation, Dysphasia-Oropharyngeal, Difficulty in	F 279		

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F 279	Continued From page 11 Walking, Muscle Weakness-General, Attention to Gastrostomy, Personality Disorder, Congestive Heart Failure, Pneumonia, Organism NOS (Not Otherwise Specified), and Hyperlipidemia. Resident #2 resided in: Room #108A from 8/13/09 through 8/16/09; Room #116A (Secured Unit) from 8/16/09 through 8/22/09; Room #407B from 8/22/09 through 8/25/09, and then transferred to current room on 8/25/09, where he was residing throughout the course of the survey from 10/20/09 through 10/26/09. The Psychiatric Consultation, dated 9/3/09 stated: "...The patient was initially admitted to the 400 Hall but was noted to be wandering and thus the patient was transferred to the closed dementia unit...According to the staff, the patient has been wandering around the unit, going into other patients' rooms. He is under contact isolation secondary to C-difficile infection..." Physician's Telephone Orders included as follows: 8/16/09: "Stool for C-diff. Dietary Consult." 8/20/09: "Imodium 2 mg (1) thru g-tube q (every) 4 hours, indication: diarrhea. Notify doctor of pending C-diff result." 8/25/09: "Contact Isolation." 9/7/09: "Stool for C-diff x 1 if negative may D/C (discontinue) isolation." 9/23/09 1330 (1:30 PM): D/C 2nd stool for C-diff. D/C Contact Isolation. 10/3/09: "Stool C-diff x2 (tapering Vanco (Vancomycin)..." (The Physician's Order indicates a tapering dosage of Vancomycin over a total period of 7 weeks.) 10/6/09: "Contact Isolation for + (positive) C-diff."	F 279		

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Nurses Notes indicated Resident #2 had episodes of diarrhea/loose stool from 8/16/09 through 8/27/09; and 10/3/09 through 10/8/09. The Lab (Laboratory) Results included as follows:
8/20/09: Positive
9/11/09: Positive
9/22/09: Negative
10/6/09: Positive

The Care Plan 8/21/09 stated: "Infection D/T (due to) C-diff (Colostrum Difficile)", and "Contact Isolation, Positive C-diff. Approach Plan: Maintain isolation precautions per policy and procedure...Explain to resident and visitors of isolation's procedure. Provide activities (room visits) per resident's preference." The file contained a Short Term Care Plan which stated: "9/14/09, 10/4/09: Antibiotic Therapy R/T (related to) loose stools. 10/6/09: C-diff Contact Isolation."

There was no care plan specifically indicating how the facility would ensure how contact isolation would be maintained for Resident #2 due to his wandering behaviors and how other residents would be protected.

Interview with the Director of Nursing and the Administrator (Executive Director) on the afternoon of 10/22/09 and 10/23/09, revealed there was no policy specific to the Secured Unit (the designated area for residents who wander) regarding how isolation precautions would be maintained to prevent the transmission of infection.

Observation

There were no gloves or gowns available at the

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F 279	Continued From page 13 resident's room entrance throughout the course of the survey on 10/20/09, 10/21/09, 10/22/09, 10/23/09, and 10/26/09. On 10/21/09 in the morning, a confused female resident was observed lying on Resident #2's bed. (Nursing staff did not appear to realize that the resident had entered the room until the surveyor pointed this out.) The resident was subsequently led out of the room and into the Activity Room by a Certified Nursing Assistant (CNA). The CNA did not take steps to wash the female resident's hands. Within approximately 2 minutes, a housekeeping staff member walked into the room, picked up some trash, and walked out to dispose of it in the main cart. The staff member then walked right into another resident's room across the hall and picked up trash and clothing without washing her hands and/or using gloves. Surveyor: 13766 Resident #24 Resident #24's Care Plan dated 9/13/09, under, Concern/Problem documented "Conjunctivitis Tobradex 1 gtt (drop) x (times) a day." (Note: Lippincott Williams & Wilkins Nursing Drug Handbook for 2009 described Tobradex Eye Drops as indicated use for Bacterial Conjunctivitis). The Care Plan for Resident #24 lacked documentation concerning Contact Precautions, patient and/or staff education for prevention of spread of infection to other residents, or disposal of any materials that came in contact with the resident's eyes such as tissues.	F 279		

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F 279	Continued From page 14 Resident #28 Resident #28 was a 78 year old male admitted to the facility on 9/26/06, and readmitted on 1/30/08, with diagnoses to include Hypoglycemia, Atrial Fibrillation, Urinary Tract Infection, Hypertension, Diabetes Insipidus, Muscle Weakness and Difficulty Walking. Resident #28's medical record contained a Physician's Order dated 9/23/09, for "Vigamox 0.5% Eye Drops one drop to both eyes 3 times a day times 7 days-itchy, dry, puffy eyes." (Note: Lippincott Williams & Wilkins Nursing Drug Handbook for 2009 described Vigamox Eye Drops as indicated for use for Bacterial Conjunctivitis) Resident #28's Plan of Care indicated the following: "Concern/Problem -9/23/09 Conjunctivitis /Vigamox opth (ophthalmic) gtts (drops) 3 times day - 10/16/09, Erthromycin both eye inf (presume infection) times 2 weeks ----both eye gtts (drops) times 2 weeks eye inf warm compress eyes --- -both eyes times 2 weeks eye infection -10/19/09-Bacitration Ophthalmic Ointment to both eyes times 2 weeks" There is no documentation under, "Approach Plan" for resident teaching concerning hand washing, any type of Contact Isolation to prevent the spread of infection to other residents, or the disposal of any materials that came in contact with the patient's eyes (such as tissues).	F 279		
F 309 SS=D	483.25 QUALITY OF CARE	F 309		

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F 309	Continued From page 15 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 25418 Based on observation, interview and record review, the facility failed to ensure necessary care and services were provided for 3 of 31 residents (Residents #18, #19, #4). Findings include: Resident #18 Resident #18 was a 58 year-old male admitted on 10/17/06, and readmitted on 9/28/09, with diagnoses including Acute Pancreatitis, Cerebral Palsy, Mental Retardation, Quadriplegia, Severe Contractures and Chronic Cystitis and Urinary Tract Infection. Resident #18's clinical record included a 10/16/09 physician's order for skilled occupational therapy (OT) to provide " ... contracture management of the upper extremities using modalities ..." During the week of the survey (10/20 - 10/23/09), Resident #18 was observed several times a day without any kind of hand splint being used to address the hand contractures. On 10/23/09 in the afternoon, Resident #18 was	F 309		

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observed with a metal tube (approximately 3/4 of an inch in diameter) in the right hand.

Resident #19

Resident #19 was originally admitted 7/22/09, and readmitted on 8/27/09, with diagnoses including coronary artery disease with coronary artery bypass graft times four, aortic valve replacement and permanent pacemaker placement in January 2009, aortic valve endocarditis in May 2009, congestive heart failure, hypertension, urinary tract infection and conjunctivitis.

Resident #19's Physician Admission Orders, dated 8/27/09 read, "Contact isolation (L) (left) eye MRSA (Methicillin-resistant Staphylococcus aureus).

On 10/23/09 in the morning, the Medication Nurse came into Resident #19's room to administer the resident's eye drop. The nurse placed a drop in the left eye and then informed the resident she was going to put a drop in the right eye as well.

When the nurse said she was going to place a drop into Resident #19's right eye, the resident said, "Oh, in both eyes now?"

The nurse replied, "Uh huh."

After the nurse left the room, Resident #19 (who was alert and oriented to person, place, day and time) was interviewed. The Resident indicated they started putting the drops in both eyes "three days ago."

Resident #19's October 2009 medication administration record (MAR) revealed the resident

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was to receive Tobradex eye drops one drop to left eye three times a day (began on 8/27/09).

On 10/26/09 in the morning, the nurse who had administered the eye drops to Resident #19 was interviewed. The nurse replied, "I made an error - I should have only put it in the left eye."
Surveyor: 27178

Resident #4

Resident #4 was admitted on 11/08/08, with diagnoses including Alzheimer's Dementia, Cerebrovascular Accident with Left Dense Hemiparesis and Left Hand Flexion Contracture, History of Anemia, Chronic Sigmoid Colon Distention, Left foot drop, Chronic Ileus, Osteoarthritis and Chronic Pain Syndrome.

The Physician's order, dated 12/23/08 revealed, a left hand splint was to be worn by Resident #4:
- from 7 AM to 11 AM,
- off from 11 AM to 3 PM,
- on from 3 PM to 7 PM, and
- off from 7 PM to 7 AM.

On 10/20/09, Resident #4 did not have the left hand splint on per schedule as ordered.

On 10/21/09, Employee # 21 revealed, "I didn't realize she had a hand splint. I didn't put it on her yesterday because I was not aware of it. She didn't wear it at all yesterday. I only found out about the hand splint when I found it on her this morning."

On 10/21/09 at 9:50 AM, Employee #23 revealed, "I was the one who put it on her. It should have been on since 7, but I didn't notice she didn't have

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F 309	Continued From page 18 it on until around 9." The Medication Administration Record (MAR) for the left hand splint schedule was signed by Employee #20 which indicated, the splint schedule was followed on 10/20/09. On 10/22/09 at 12:15 PM, Employee #20 revealed, "I signed off on the splint because I assumed it was on her. I didn't really check because her arms were covered with blanket. I shouldn't have signed the MAR."	F 309		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Surveyor: 27178 Based on observation, interview, policy review, and record review, the facility failed to conduct comprehensive assessments for 2 of 31 residents with limited range of motion (#4, #15). Findings include: Resident #15: Resident #15 was admitted on 12/16/07, with diagnoses including Diabetes Mellitus, Hypertension, Hyperlipidemia, Degenerative	F 318		

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F 318	Continued From page 19 Neuropathy, Debility, History of Oral Cancer, and Seizure Disorder. On 10/21/09 in the afternoon, Resident # 15 was noted to have bilateral foot drop. Resident #15 revealed it had been discussed many times in the past several months, but the facility had not provided any interventions to prevent the foot drop. On 10/22/09 in the morning, Employee #18 revealed that on 9/29/09, "I was looking for a pillow or a wedge to use for her foot drop but I got side tracked; I must not have written a referral for PT (Physical Therapy) to screen her." On 10/22/09 at 10:40 AM, the Director of Rehabilitation revealed, "All new residents get screened upon admission and on a quarterly schedule. Also, if a resident's name is flagged in the Quality Indicator's report, it tells us to take a look at the resident." The Director of Rehabilitation further revealed, "Nursing can also refer to us if they suspect that a resident needs to be screened or evaluated." The Director of Rehabilitation continued, "Based on the Quality Indicators printed on 9/11/09, with report period of 3/1/09 to 8/31/09, (Resident #15) was not listed." The Director of Rehabilitation indicated Resident #15 would be screened as soon as possible. Social Services Progress Notes, dated 6/24/09 revealed, "SW (Social Worker) left message for res (resident) sister for IDT (interdisciplinary team) meeting regarding PT that res verbalized	F 318		

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she would like to have, and the foot rest for resident's drop feet."

Resident #4

Resident #4 was admitted on 11/08/08, with diagnoses including Alzheimer's Dementia, Cerebrovascular Accident with Left Dense Hemiparesis and Left Hand Flexion Contracture, History of Anemia, Chronic Sigmoid Colon Distention, Left foot drop, Chronic Ileus, Osteoarthritis and Chronic Pain Syndrome.

The Minimum Data Set, dated 2/17/09, 5/19/09 and 8/18/09 revealed, Resident #4 had limited range of motion to the leg and the foot with no loss of voluntary movement.

On 10/22/09, Resident #4's feet were noted to have foot drop.

The Physical Therapy notes, dated 11/19/08 revealed, Resident #4 would tolerate the use of bilateral foot/ankle positioning device for plantar flexion contracture for 4 hours.

The Physical Therapy notes, dated 12/31/08 revealed, "Pt. (Patient) has been on PT program since 11/19/08. Pt. shows significant gains with BLE (bilateral lower extremity) ROM (range of motion). This allowed nursing to do better pericare. On initial evaluation, pt's LE (lower extremities) were in extension...Patient has tolerated use of bilateral foot drop splint for at least 6 hours. Nursing and family has been instructed with use of splints. Pt. ready for discharge from PT program..."

The Nurses Notes, dated 12/31/08 revealed,

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F 318	Continued From page 21 "BLE worn @ (at) 7 AM and taken off at 11 AM." The Nurses Notes, dated 1/11/09 indicated, "Patient's son states that he doesn't want her (Resident #4) to use the boots anymore because he cant bend the knees but wants the hand splint on." There was no care plan found in Resident #4's chart addressing the foot drop, which was confirmed by the Director of Nurses (DON) on 10/22/09 in the afternoon. The DON further confirmed the lack of assessments and interventions in preventing further foot drop. On 10/22/09, the DON and the Medical Records Department were unable to provide IDT (Interdisciplinary Team) notes, physician's notes addressing the discontinuation of the bilateral foot splints per Resident #4's son's request. The Contracture Management Policy, Revised 11/02/2004 revealed: "Process: 1. Upon admission, the Rehabilitation Department should screen/assess all patient/patients for functional mobility and positioning needs....4. Screen patients quarterly to assess for any changes in positioning needs."	F 318		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 22 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 25418 Based on observation, document review and interview, the facility failed to properly store and secure drugs and biologicals and maintain them at proper cooling temperatures. Findings include: On 10/23/09 in the morning, the Medication Nurse was observed with medication cart #2 on the 400	F 431		

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F 431	Continued From page 23 hall. During the process of delivering medications to three different residents, the medication cart was left unlocked. On 10/23/09 in the morning, the temperature inside refrigerator #1 in the 400 hall medication room was 51 degrees Fahrenheit. There was a large amount of ice in the freezer area. On 10/23/09 in the morning, the temperature inside refrigerator #2 in the 400 hall medication room was 30 degrees Fahrenheit. According to the Refrigerator Control Log posted on each unit, "... and Medication should be at 36 degrees - 45 degrees." The unit manager (UM) was present for the refrigerator inspections. The UM confirmed the temperature for each refrigerator was supposed to be between 36 degrees - 45 degrees. Surveyor: 27178 On 10/23/09 at 11:00 AM, a medication drawer in the medication cart, where medication bubble packs were kept, 16 loose pills were found in the bottom of the drawer. On 10/23/09, Employee #20 revealed, "I don't know exactly what they are. They must have fell off from the old bubble packs." The Medication Storage Policy, last revised 6/21/06 revealed, "Medication containers that are damaged or poorly labeled must be returned to the pharmacy for relabeling or disposal, if permitted by state law."	F 431		
F 441 SS=F	483.65(a) INFECTION CONTROL	F 441		

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The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Surveyor: 12211

Based on observation, interview, policy review, and record review, the facility failed to ensure infection control procedures were maintained to prevent the transmission of infection.

Findings include:

Resident #26

Resident #26 was a 93 year old female admitted 4/15/08, with diagnoses including Late Effective Hemiplegia Non-dominant, Difficulty Walking, Muscle Weakness, Dysphasia Oropharyngeal, Dementia, Cerebral Vascular Accident, Coronary Artery Disease, Thyroid Disease, Urinary Incontinence, and General Weakness.

The room Resident #26 resided on 10/20/09, 10/21/09, 10/22/09, 10/23/09, and 10/26/09, did not have a sign indicating any contact precautions to be taken by staff, residents, and visitors.

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Nursing Notes 10/17/09 1100 (11:00 AM) indicated, "Noted resident's left eye is red and has yellowish drainage. Notified (name of treating physician) and noted order for erythromycin eye ointment 1/2 inch ribbon twice a day x 7 days to left eye..." There was no documented evidence in the Nursing Notes that any contact precautions were put into place for Resident #26.

There was no documentation of an assessment for Resident #26 regarding whether the left eye redness with yellow drainage was Conjunctivitis and contagious. The Care Plan, dated 10/17/09, did indicate that antibiotics for the left eye were prescribed; however, there was no documented evidence of a care plan for contact precautions.

Resident #2 (First concern)

Resident #2 was an 84 year old male admitted 8/13/09, with diagnoses including Atrial Fibrillation, Dysphasia-Oropharyngeal, Difficulty in Walking, Muscle Weakness-General, Attention to Gastrostomy, Personality Disorder, Congestive Heart Failure, Pneumonia, Organism NOS (Not Otherwise Specified), and Hyperlipidemia.

Resident #2 resided in:
- Room #108A from 8/13/09 through 8/16/09;
- Room #116A (Secured Unit) from 8/16/09 through 8/22/09;
- Room #407B from 8/22/09 through 8/25/09, and
- Then transferred to Room #116B on 8/25/09, where he was residing throughout the course of the survey from 10/20/09 through 10/26/09.

The Psychiatric Consultation, dated 9/3/09 stated: "...The patient was initially admitted to the 400 Hall but was noted to be wandering and thus the

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F 441	Continued From page 26 patient was transferred to the closed dementia unit...According to the staff, the patient has been wandering around the unit, going into other patients' rooms. He is under contact isolation secondary to C-difficile infection..." The Care Plan 8/21/09 stated: "Infection D/T (due to) C-diff (Colostrum Difficile)", and "Contact Isolation, Positive C-diff. Approach Plan: Maintain isolation precautions per policy and procedure...Explain to resident and visitors of isolation's procedure. Provide activities (room visits) per resident's preference." The file contained a Short Term Care Plan which stated: "9/14/09, 10/4/09: Antibiotic Therapy R/T (related to) loose stools. 10/6/09: C-diff Contact Isolation." Physician's Telephone Orders included as follows: 8/16/09: "Stool for C-diff. Dietary Consult." 8/20/09: "Imodium 2 mg (1) thru g-tube q (every) 4 hours, indication: diarrhea. Notify doctor of pending C-diff result." 8/25/09: "Contact Isolation." 9/7/09: "Stool for C-diff x 1 if negative may D/C (discontinue) isolation." 9/23/09 1330 (1:30 PM): D/C 2nd stool for C-diff. D/C Contact Isolation. 10/3/09: "Stool C-diff x2 (tapering Vanco (Vancomycin)..." (The Physician's Order indicates a tapering dosage of Vancomycin over a total period of 7 weeks.) 10/6/09: "Contact Isolation for + (positive) C-diff." Nurses Notes indicated Resident #2 had episodes of diarrhea/loose stool from 8/16/09 through 8/27/09; and 10/3/09 through 10/8/09. The Lab (Laboratory) Results included as follows:	F 441		

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F 441	Continued From page 27 8/20/09: Positive 9/11/09: Positive 9/22/09: Negative 10/6/09: Positive Observation There were no gloves and gowns, or masks available at the resident's room entrance throughout the course of the survey on 10/20/09, 10/21/09, 10/22/09, 10/23/09, and 10/26/09. On 10/21/09 in the morning, a confused female resident was observed lying on Resident #2's bed in Room #116. (Nursing staff did not appear to realize that the resident had entered the room until the surveyor pointed this out.) The resident was subsequently led out of the room and into the Activity Room by a Certified Nursing Assistant (CNA). The CNA did not take steps to wash the female resident's hands. Within approximately 2 minutes, a housekeeping staff member walked into Room #116, picked up some trash, and walked out to dispose of it in the main cart. The staff member then walked right into another resident's room across the hall and picked up trash and clothing without washing her hands and/or using gloves. Policy Review Clostridium Difficile, last revised 5/21/04: "Purpose: To prevent transmission of Clostridium difficile (C. difficile). Contact Precautions: Residents with diarrhea caused by C. difficile should be in private rooms or in the same room with other residents with C. difficile. If neither of the above rooming situations is available, contact the Regional Director of Clinical Services or other	F 441		

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designee to review the specific resident situation to determine if a semi-private room with a low risk roommate is acceptable. Gloves should be worn to enter the room of a resident who has diarrhea caused by C. difficile. A gown is needed to enter the room of a resident who has diarrhea caused by C. difficile if substantial contact with the resident or environmental surfaces is anticipated. Gowns and gloves should be removed before leaving the resident's room and hands must be washed immediately following hand hygiene guidelines. Alcohol-based hand rubs do not kill spore-forming organisms. Staff will use anti-microbial soap and water or non-antimicrobial soap and water for hand washing. Items such as stethoscope, sphygmomanometer, and rectal thermometer should be dedicated to use on that resident only or a cohort of C. difficile residents. Contact precautions may be discontinued once diarrhea has ceased. Sanitize fecally-soiled areas with facility approved germicidal agent."

Standard Precautions, last revised 5/21/04:
"Purpose: It is the intent of this facility that: (1) all resident blood and body fluids will be considered potentially infectious and (2) standard precautions are indicated for all residents. Barriers Indicated in Standard Precautions:
Gloves-should be worn whenever exposure to the following is planned or anticipated:
Blood / blood products / body fluids with visible blood;
Urine;
Feces;
Saliva;
Mucous membranes;
Wound drainage;
Drainage tubes;
Non-intact skin;

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F 441	Continued From page 29 Amniotic, cerebral spinal, pericardial, pleural, peritoneal, and synovial fluids; Performing venipuncture or invasive procedures. Masks-should be worn during procedures that are likely to generate droplets / splashing of blood / body fluids. Masks should be worn within 3 feet of the resident if droplets are expected as would occur in coughing, sneezing, talking, and/or suctioning. Gowns/aprons-should be worn when there is potential for soiled clothing with blood/body fluids. Eyewear-protection over the eyes should be worn during procedures that are likely to generate droplets of blood/body fluids. Private Room-consider when resident hygiene is poor or in cases where bloody/body fluids cannot be contained..." Contact Precautions, last revised 5/21/04: Purpose: It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the residents' environment. Barriers Indicated for Contact Precautions: Contact precautions shall be used in addition to standard precautions for residents with infections that can easily be transmitted by direct and indirect contact. Resident Placement: The resident may be placed in a private room. If a private room is not needed / not available, the resident may be placed in a room with a resident(s) who has active infection with the same organism but with no other infection. When a private room is not available and cohorting is not an option, consider the organism and resident population when determining placement. A decision will be made on a	F 441		

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case-by-case basis regarding the safety of placing the resident in a room with another resident. Examples of residents that may require a private room include residents with resistant organisms who have copious (not contained) drainage from a wound, residents with poor hygiene, residents with behavior that cannot be positively influenced, etc.
Gloves & Handwashing:
Gloves should be worn when entering the room and while providing care for a resident in a private room. If it's a shared room, gloves will be worn on entering side of room (to perform functions) where resident with infection is located.
Gloves should be changed after having contact with infected material (e.g., fecal material and wound drainage).
Gloves should be removed before leaving the resident's room, and hand hygiene should be performed.
After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items.
Gowns:
A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent or wound drainage is not contained by a dressing.
If a gown is worn, it should be removed before leaving the resident's room.
After removal of the gown, clothing should not contact potentially contaminated environmental surfaces.
Resident Transport:
Activities of the resident may need to be limited. This will be determined on a case-by-case basis.
If the resident leaves the room, precautions

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should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.
Resident Care Equipment:
Dedicated resident care equipment should be considered for the resident.
If use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident.
Examples of Infections When Contact Precautions May Be Considered:
Multi-resistant organisms (e.g., VRE (Vancomycin Resistant Enterococcus)), Scabies, Clostridium difficile."
Surveyor: 13766

Resident #2 (Second concern)

The Care Plan for Resident #2, dated 8/21/09 stated: "Infection D/T (due to) C-diff (Colostrum Difficile)", and "Contact Isolation, Positive C-diff. Approach Plan: Maintain isolation precautions per policy and procedure...Explain to resident and visitors of isolation's procedure. Provide activities (room visits) per resident's preference." The file contained a Short Term Care Plan, which stated: "9/14/09, 10/4/09: Antibiotic Therapy R/T (related to) loose stools. 10/6/09: C-diff Contact Isolation."

On 10/21/09 in the morning, the Medication Nurse for Hall one on the Alzheimer's Unit indicated she was going to flush Resident #2's gastrostomy tube. The nurse removed a 50cc (cubic centimeter) syringe from the medication cart, which was contained in an already open plastic bag with Resident #2's name on the bag. She proceeded to use the syringe on Resident #2

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place the 50cc syringe back in the original plastic bag that was sitting on the resident's night stand and placed it back in the draw of the medication cart. The nurse indicated she kept it in the medication cart because she could not leave it at the resident's bedside.

Resident #24

Resident #24 was an 89 year old male admitted to the facility on 8/25/09, with diagnoses to include Alzheimer's Disease, History of falls, General Osteoarthritis, Chronic Kidney Disease and Hypertension.

Resident #24's Care Plan, dated 9/13/09 under, Concern/Problem documented, "Conjunctivitis Tobradex 1 gtt (drop) x (times) a day." (Note: Lippincott Williams & Wilkins Nursing Drug Handbook for 2009 described Tobradex Eye Drops as indicated use for Bacterial Conjunctivitis).

The Medication Administration Record for Resident #24 dated 9/13/09, "Tobradex Ophthalmic one drop to each eye three times a day for 5 days for redness and itchiness". The eye drops were administered to the resident on 9/15/09, 9/16/09, 9/17/09, 9/18/09 and 9/19/09. The medication was discontinued after the last dose on 9/19/09.

There was no documentation that indicated if Resident #24 had been on Contact Isolation. Nor was no documentation that indicated the resident had any discharge or drainage from his eyes.

Resident #28

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Resident #28 was a 78 year old male admitted to the facility on 9/26/06, and readmitted on 1/30/08, with diagnoses to include Hypoglycemia, Atrial Fibrillation, Urinary Tract Infection, Hypertension, Diabetes Insipidus, Muscle Weakness and Difficulty Walking.

Resident #28's medical record contained a Physician's Order dated 9/23/09, for "Vigamox 0.5% Eye Drops one drop to both eyes 3 times a day times 7 days-itchy, dry, puffy eyes." (Note: Lippincott Williams & Wilkins Nursing Drug Handbook for 2009 described Vigamox Eye Drops as indicated for use for Bacterial Conjunctivitis).

A Consultation from an Ophthalmologist, dated 10/16/09, documented an order for Erythromycin Ointment at hour of sleep in both eyes. (Note: Lippincott Williams & Wilkins Nursing Drug Handbook for 2009 described Erythromycin Ointment for Chronic and Acute Conjunctivitis and other infections of the eye).

On 9/23/09 at 11:30 AM, the Nurses Notes for Resident #28 indicated he had puffiness, redness and itchiness around both eyes. He was advised by the nurse not to rub or touch his eyes. The resident was placed on antibiotic eye drops according to the documentation on 9/23/09. The notes indicated the resident ate in the dining room and attended activities of his choice. There was no documentation that indicated the staff consulted with the physician whether the resident should be on any contact isolation.
The Nurses Notes indicated the resident went to the dining room to eat and attended activities though September and October of 2009.

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On 10/22/09 at lunch time, Resident #28 indicated he was informed by the staff he could not leave his room. He indicated "all of a sudden I can't leave my room, I have been eating in the dining room and going to activities for weeks since I had this eye condition."

During the Medication Pass on the 200 Hall on 10/21/09 in the morning, the Medication Nurse took the blood pressure of the resident in Room 200 and put the cuff back in the Medication Cart without wiping it with sanitizer.

On 10/21/09 at 11:30 AM, the Medication Nurse took blood from Resident #28 and returned the glucometer to the medication Cart without wiping it with sanitizer.
Surveyor: 25418

Resident #5

Resident #5 was a 90 year-old female originally admitted to Room 404A on 5/25/09 and readmitted (Room 427A) on 10/19/09 with diagnoses including Left Lower Lobe Pneumonia, Coag-Negative Staphylococcus Bacteremia, Dementia, Stage IV Coccyx Pressure Ulcer and Urinary Tract Infection.

A nursing note dated 6/4/09, indicated Resident #5 was receiving intravenous (IV) antibiotics "for pneumonia".

A nursing note dated 6/17/09, indicated Resident #5's stool was positive for Clostridium difficile (C. Diff).

A nursing note dated 6/19/09, indicated the resident was placed on contact isolation two days

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after the diagnoses of C. Diff. There was no documented evidence in the clinical record indicating the resident was placed on contact isolation at the time of the diagnoses.

A nursing note dated 7/1/09, indicated Resident #5's stool was negative for C. Diff.

A nursing note dated 7/13/09, indicated Resident #5's stool was positive for C. Diff.

A nursing note dated 7/17/09, indicated Resident #5's stool was positive for C. Diff.

According to documentation in the clinical record, Resident #5 was transferred via paramedics to an acute care facility (ACF or also known as a hospital) on 10/10/09. The resident's nares were swabbed. Results from the lab revealed growth of Methicillin Resistant Staphylococcus Aureus (MRSA).

The 10/17/09 Transfer Summary written by the ACF physician revealed Resident #5 was diagnosed with MRSA bacteremia, urinary tract infection and left lower lobe pneumonia.

Resident #18

Resident #18 was a 58 year-old male admitted on 10/17/06, and readmitted on 9/28/09, with diagnoses including Acute Pancreatitis, Cerebral Palsy, Mental Retardation, Quadriplegia, Severe Contractures and Chronic Cystitis and Urinary Tract Infection.

On 9/25/09, Resident was transferred to an acute care facility (ACF) secondary to pain in the right hip.

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During his three day admission at the ACF, Resident #18 was diagnosed with Methicillin resistant Staphylococcus aureus (MRSA) in the urine and nares. The resident's stool tested positive for Clostridium difficile (C. Diff).

On 9/28/09, Resident #18 was transferred from the ACF to Life Care Center of Las Vegas.

On 9/30/09, Resident #18 was transferred from Room 121A to Room 429B and placed on contact isolation for MRSA in the urine and respiratory isolation for MRSA in the nares.

According to a nursing note dated 10/12/09 at 7:00 AM, Resident #18 was "still on respiratory isolation." There was no mention in the nursing note of contact isolation being observed.

Resident #19

Resident #19 was a 79 year-old male admitted on 7/22/09, with diagnoses including Coronary Artery Disease, Congestive Heart Failure, Benign Prostatic Hypertrophy, Hypertension, Urinary Tract Infection, status post Coronary Artery Bypass Graft of Four and Bacterial Endocarditis secondary to Coronary Valve Tissue Replacement, Generalized Weakness and Difficulty Walking.

An 8/20/09 History and Physical revealed, Resident #19 was transferred by paramedics to an acute care facility (ACF) with unresponsiveness, generalized debility, weakness and poor appetite.

An 8/27/09 Discharge Summary revealed,

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F 441	Continued From page 37 Resident #19 was diagnosed with and treated for Klebsiella Urosepsis, Septic Shock and Staphylococcal Conjunctivitis of the left eye during admission at the ACF. The resident returned and was placed in Room 429B. Lab results dated 9/8/09 revealed, Resident #19 had positive growth of Methicillin resistant Staphylococcus aureus (MRSA) in the right nare. There was a physician's order for Bactroban ointment twice a day for 10 days and respiratory isolation. A 9/9/09 Activity Progress Note revealed Resident #19, " ... continues to participate in skilled PT/OT (physical therapy/occupational therapy) ..." On 10/23/09 in the morning, the Medication Nurse with cart #2, on the 400 hall, was observed removing her gloves while exiting a resident's room. The nurse failed to perform hand hygiene prior to preparing the next resident's medications. The nurse put a new pair of gloves on and went into the resident's room to give the medications. Dining Room On 10/23/09 at 6:53 AM, two female residents were sitting across from each other at a table in the 200 hall lounge. An unsampled staff member was observed feeding both residents, a bite at a time, alternating between the two of them.	F 441		
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	Continued From page 38 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observations, interviews and documentation reviews, the facility failed to ensure identification of quality deficiencies and develop and implement appropriate plans of actions for their infection control program and clearly define in their policy for abuse and neglect a clear distinction for resident to resident sexual abuse. Findings include: 1. The Infection Comprehensive Control Program failed to accurately identify residents who were placed on Contact Isolation. There was ineffective monitoring of staff practices to ensure proper	F 520		

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precautions were taken to contain the infection from spreading to others.

- The Infection Control Nurse was inaccurately tracking facility acquired infections as opposed to community acquired infections on the infection control tracking map.

-The Infection Control Program failed to identify residents who were transferred out with an infection to the hospital and returned after treatment for that particular infection. Any resident who returned from the hospital on antibiotics was grouped in as a community acquired infection. This practice would create inaccuracies of the performance improvement data. For example, if a resident went out for a urinary tract infection to the hospital and was treated with antibiotics, when the resident returned to the facility that would be considered a community acquired infection. In reality the resident acquired the infection while at the facility and should be counted as a facility acquired infection.

-The facility had no policy or procedure for a resident who was confused, disoriented and non-compliant with an infection that could potentially infect other residents in his area.

-The Infection Control Nurse and the Director of Nursing indicated they were taking precautions on a individual basis for each resident. The facility had no policy in place if an infection spread throughout the Alzheimer's Unit and how it could be contained.

-Staff were observed not practicing isolation precautions although the physician had written orders to provide such precautions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295052	A. BUILDING _____ B. WING _____	10/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF LAS VEGAS	6151 VEGAS DRIVE LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 40 -The facility did not confer with the resident's attending physicians to ascertain the extent of contagion of several cases of conjunctivitis that were identified as facility acquired. -There was no documentation presented during the survey that the facility presented an on going program of in-serving with staff on a monthly basis as indicated by the Infection Control Nurse. -Residents who were identified as being on Contact Isolation precautions were observed and documented eating in the dining room and attended activities. -There was no documentation that the residents who were alert and oriented were educated that their condition (Conjunctivitis) could be spread by poor hand hygiene and infected tissues and other objects.(see Tag 441) 2. The facility abuse policy lacked documentation of a clear distinction for resident to resident sexual abuse. The policy states, "Protection of Residents: Reducing the Threat of Abuse & Neglect, Chapter 2 (no date or revision)" indicated under definitions, "Sexual Abuse Includes, but not limited to, sexual harassment, sexual coercion or sexual assault." The policy is unclear in defining what is considered, "harassment", "coercion" and "assault". The policy failed to indicate if an alert resident victimizes a confused resident or if a confused resident victimizes another confused resident.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 41 (Also see Tag 226.)	F 520		